Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MedALERT Occupational Management, Inc.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-15-1320-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please be advised that this letter and enclosed information is in response to your recent payment of the 99455 V4 CPT Code billed on the Workers' Compensation claim for the patient mentioned above. This was both the initial and final visit in our clinic for this patient as documented in the attached medical record. After thorough examination, [the injured employee] was release the same day to return to work without restrictions.

The Texas Medical Fee Guidelines outline specific instructions for appropriately releasing a patient in accordance with the DWC rules and regulations. It is our understanding that the 99455 CPT code is to be used in place of the 99204 E & M code. Due to this unique circumstance, we are requesting an additional allowance of $90.70, the remainder of what we are entitled for an initial level 4 office visit."

Amount in Dispute: $90.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on January 6, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 8, 2014	Treating Doctor Examination to determine MMI/IR	$90.70	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Division-specific services.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
   - OA – The amount adjusted is due to bundling or unbundling of services.
   - 247 – A payment or denial has already been recommended for this service.

Issues

1. What is the correct MAR for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced the disputed services based on fee guidelines. The requestor disagrees with the reduction, stating, "It is our understanding that the 99455 CPT code is to be used in place of the 99204 E & M code." 28 Texas Administrative Code §134.204 (j)(3)(A) states, "An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier. (i) Reimbursement shall be the applicable **established patient office visit level** associated with the examination. (ii) Modifiers 'V1', 'V2', 'V3', 'V4', or 'V5' shall be added to the CPT code to correspond with the last digit of the applicable office visit" [emphasis added].

   Review of the submitted documentation finds that the requestor billed CPT Code 99455-V4. Therefore, the applicable established patient office visit level associated with the examination for reimbursement is 99214.

   CPT Code 99214 for date of service August 8, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 1.521. The practice expense (PE) RVU of 1.41 multiplied by the PE GPCI of 1.013 is 1.42833. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.803 is 0.0803. The sum of 3.02963 is multiplied by the Division conversion factor of $55.75 for a MAR of $168.90.
2. The total allowable for the disputed services is $168.90. The insurance carrier paid $168.90. Therefore, no further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	April 7, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.